

TABLE B-4 (CONTINUED--11 OF 28)

	Small	Medium	Large
10. a. (Continued)			
Administrator and medical director and governing body and other	0 0	0 1	0 0
Administrator and medical director and other.	0 0	0 0	15 0
Administrator and other	2 4	0 3	0 0
Governing body.	23 36	27 33	15 16
Governing body and other.	0 1	0 4	10 4
Medical director.	2 1	4 2	5 0
Medical director and governing body	4 1	4 0	0 0
Medical director and governing body and other	0 0	0 0	0 0
Medical director and other.	0 0	0 0	0 0
Other	0 2	0 2	0 8

b. Supplies or recurring items:			
Administrator	78 89	85 85	79 88
Administrator and governing body.	10 2	4 5	0 4
Administrator and governing body and other.	0 1	4 0	0 0
Administrator and medical director.	0 3	4 4	5 0
Administrator and medical director and governing body	4 0	0 0	0 0
Administrator and medical director and governing body and other	0 0	0 0	0 0
Administrator and medical director and other.	0 0	0 0	5 0
Administrator and other	2 3	4 2	5 0
Governing body.	4 0	0 0	0 0
Governing body and other.	0 0	0 0	5 4

TABLE B-4 (CONTINUED--12 OF 28)

10. b. (Continued)	Small	Medium	Large
Medical director.	2 0	0 0	0 0
Medical director and governing body	0 0	0 0	0 0
Medical director and governing body and other	0 0	0 0	0 0
Medical director and other.	0 0	0 0	0 0
Other	0 2	0 4	0 4

11. Lay administrator's involvement in personal business affairs of physicians:

Never. . . .	9 8	4 7	5 4
Seldom . . .	47 41	54 55	35 48
Often. . . .	23 30	29 25	35 36
A great deal	21 22	13 13	25 12

12. Scheduled hours of service provided by the group practice
a. Full service hours on Monday--Friday:

0	0 1	4 1	0 0
1--3.	0 0	0 1	0 0
4--6.	0 1	0 1	0 0
7--9.	74 77	69 65	70 72
10--12	17 19	27 29	20 23
13--15	6 2	0 3	5 0
16--18	0 0	0 0	0 0
19--21	0 0	0 0	0 0
22--24	4 0	0 0	5 0

TABLE B-4 (CONTINUED--13 OF 28)

12. (Continued)

b. Full service hours on Saturday:

	Small	Medium	Large
0	45 53	35 35	35 55
1--3.	17 14	12 9	20 12
4--6.	23 27	46 45	40 28
7--9.	9 5	8 8	0 4
10--12	0 0	0 4	0 0
13--15	2 0	0 0	0 0
16--18	0 0	0 0	0 0
19--21	0 0	0 0	0 0
22--24	4 0	0 0	5 0

c. Full service hours on Sunday:

0	94 97	100 100	90 100
1--3.	2 1	0 0	0 0
4--6.	0 1	0 0	5 0
7--9.	0 0	0 0	0 0
10--12	0 0	0 0	0 0
13--15	0 0	0 0	0 0
16--18	0 0	0 0	0 0
19--21	0 0	0 0	0 0
22--24	4 0	0 0	5 0

TABLE B-4 (CONTINUED--14 OF 28)

12. (Continued)

d. Limited service hours on Monday--Friday:

	Small	Medium	Large
0	91 78	54 70	50 64
1--3.	4 7	15 11	5 8
4--6.	2 2	4 6	10 8
7--9.	0 1	0 0	0 0
10--12	0 2	8 3	15 0
13--15	2 8	12 9	15 16
16--18	2 3	4 1	5 4
19--21	0 0	0 0	0 0
22--24	0 0	4 0	0 0

e. Limited service hours on Saturday:

0	79 73	54 71	25 60
1--3.	9 9	0 5	5 0
4--6.	6 6	23 9	15 20
7--9.	2 2	0 2	5 4
10--12	0 1	0 3	20 0
13--15	0 0	0 2	0 4
16--18	2 1	4 2	5 0
19--21	0 3	12 5	20 4
22--24	2 3	8 2	5 8

TABLE B-4 (CONTINUED--15 OF 28)

12. (Continued)
f. Limited service hours on Sunday:

	Small	Medium	Large
0	93 86	73 80	55 76
1--3.	2 2	0 3	0 4
4--6.	0 1	4 5	5 0
7--9.	2 1	0 1	0 4
10--12	0 0	0 1	5 4
13--15	0 0	0 1	5 0
16--18	0 0	0 0	5 0
19--21	0 0	0 0	0 0
22--24	2 9	23 10	25 12

13. Normal staffing level in terms of full-time equivalents
a. Physicians
(1) Physician members
(1) Total positions:

0	19 9	12 6	15 16
1--10	60 77	8 7	0 0
11--20	21 14	31 48	0 12
21--30	0 0	42 29	5 12
31--40	0 0	8 11	20 20
41--50	0 0	0 0	25 16
51--60	0 0	0 0	15 8
61--70	0 0	0 0	5 4
71--80	0 0	0 0	5 8
81--90	0 0	0 0	0 4

TABLE B-4 (CONTINUED--16 OF 28)

13. a. (1) (i) (Continued)

	Small	Medium	Large
91--100	0	0	0
	0	0	0
101--110	0	0	0
	0	0	0
111--120	0	0	5
.	0	0	0
.			
250	0	0	0
	0	0	0

(ii) Filled positions:

0	19	12	20
	10	7	16
1--10.	66	8	0
	77	10	4
11--20.	15	31	0
	13	49	8
21--30.	0	42	5
	0	25	12
31--40.	0	8	20
	0	9	28
41--50.	0	0	20
	0	0	12
51--60.	0	0	15
	0	0	8
61--70.	0	0	5
	0	0	4
71--80.	0	0	5
	0	0	4
81--90.	0	0	5
	0	0	4
91--100	0	0	0
	0	0	0
101--110	0	0	5
	0	0	0
.			
.			
250	0	0	0
	0	0	0

TABLE B-4 (CONTINUED--17 OF 28)

		Small	Medium	Large
13. a. (1) (Continued)				
(iii) Vacant positions:				
	0	87 85	96 75	80 76
	1--10	13 15	4 24	15 16
	11--20	0 0	0 2	5 4
	21--30	0 0	0 0	0 4
(2) Physician employees				
(i) Total positions:				
	0	40 42	12 16	25 16
	1--10.	57 57	65 65	30 28
	11--20.	4 1	15 16	5 12
	21--30.	0 0	0 3	5 12
	31--40.	0 0	8 1	10 4
	41--50.	0 0	0 0	15 12
	51--60.	0 0	0 0	5 4
	61--70.	0 0	0 0	0 4
	71--80.	0 0	0 0	0 0
	81--90.	0 0	0 0	0 0
	91--100	0 0	0 0	5 0
	130	0 0	0 0	0 4
	167	0 0	0 0	0 4

TABLE B-4 (CONTINUED--18 OF 28)

13. a. (2) (Continued)
(ii) Filled positions:

	Small	Medium	Large
0	42 130	12 17	30 16
1--10.	55 55	68 66	25 32
11--20.	4 1	12 15	10 8
21--30.	0 0	0 2	0 16
31--40.	0 0	8 1	10 0
41--50.	0 0	0 0	15 12
51--60.	0 0	0 0	5 4
61--70.	0 0	0 0	0 4
71--80.	0 0	0 0	0 0
81--90.	0 0	0 0	0 0
91--100	0 0	0 0	5 0
.			
123	0 0	0 0	0 4
.			
167	0 0	0 0	0 4

(iii) Vacant positions:

0	94 81	84 81	85 76
1	4 6	12 6	0 4
2	0 6	0 6	0 4
3	0 6	0 6	0 0
4	0 1	4 1	0 4
5	0 1	0 1	0 0
7	0 0	0 0	5 4

TABLE B-4 (CONTINUED--19 OF 28)

	Small	Medium	Large
13. a. (2) (iii) (Continued)			
10	0 0	0 0	5 4
14	0 0	0 0	0 4
15	0 0	0 0	5 0
16	2 0	0 0	0 0
b. Non-physician employees			
(i) Total positions:			
0	0 1	0 2	0 0
1--50.	90 94	23 26	20 14
51--100	6 5	46 51	0 14
101--150	2 0	19 17	20 27
151--200	0 0	12 5	15 23
201--250	0 0	0 0	5 5
251--300	0 0	0 0	15 0
301--350	0 0	0 0	0 0
351--400	0 0	0 0	10 0
401--450	2 0	0 0	5 5
451--500	0 0	0 0	5 0
501--550	0 0	0 0	0 0
551--600	0 0	0 0	0 9
601--650	0 0	0 0	0 2
651--700	0 0	0 0	0 2
701--750	0 0	0 0	0 2
751--800	0 0	0 0	0 2
801--850	0 0	0 0	0 2
851--900	0 0	0 0	0 2
901--950	0 0	0 0	0 2
951--1000	0 0	0 0	0 2
1001--1050	0 0	0 0	0 2
1051--1100	0 0	0 0	0 2
1101--1150	0 0	0 0	0 2
1151--1200	0 0	0 0	0 2
1201--1250	0 0	0 0	0 2
1251--1300	0 0	0 0	0 2
1301--1350	0 0	0 0	0 2
1351--1400	0 0	0 0	0 2
1401--1450	0 0	0 0	0 2
1451--1500	0 0	0 0	0 2
1501--1550	0 0	0 0	0 2
1551--1600	0 0	0 0	0 2
1601--1650	0 0	0 0	0 2
1651--1700	0 0	0 0	0 2
1701--1750	0 0	0 0	0 2
1751--1800	0 0	0 0	0 2
1801--1850	0 0	0 0	0 2
1851--1900	0 0	0 0	0 2
1901--1950	0 0	0 0	0 2
1951--2000	0 0	0 0	0 2
201	0 0	0 0	2 2
201	0 0	0 0	2 2

TABLE B-4 (CONTINUED--20 OF 28)

13. b. (2) (Continued)
(ii) Filled positions:

	Small	Medium	Large
0	0 1	0 2	5 0
1--50.	90 95	23 29	20 18
51--100	6 5	46 48	0 9
101--150	2 0	19 17	15 27
151--200	0 0	12 5	15 23
201--250	0 0	0 0	5 5
251--300	0 0	0 0	15 0
301--350	0 0	0 0	0 0
351--400	0 0	0 0	10 5
401--450	2 0	0 0	5 0
451--500	0 0	0 0	5 0
501--550	0 0	0 0	0 0
551--600	0 0	0 0	0 9
.			
820	0 0	0 0	2 2
.			
1148	0 0	0 0	2 2
.			
1420	0 0	0 0	2 2

(iii) Vacant positions:

0	89 93	92 86	80 68
1	4 5	0 6	0 0
2	6 2	4 3	5 5
3	0 0	4 1	0 0

TABLE B-4 (CONTINUED--21 OF 28)

13. b. (2) (iii) (Continued)

	Small	Medium	Large
4	0 0	0 3	0 0
5	0 0	0 0	0 9
6	0 0	0 0	0 5
8	0 0	0 0	5 0
10	0 0	0 0	0 5
14	0 0	0 0	5 0
15	0 0	0 1	0 0
17	0 0	0 1	0 0
18	0 0	0 0	0 0
22	0 0	0 0	0 5
28	2 0	0 0	0 0
45	0 0	0 0	0 5
78	0 0	0 0	5 0

14. Growth of group:

Decreasing	6 2	0 2	0 0
Stable . .	38 39	27 19	10 8
Growing. .	57 59	73 80	90 92

15. Annual gross operating revenue (in thousands of dollars) generated by clinic medical staff:

0--1,000.	50 54	8 4	0 4
1,001--2,000.	40 42	16 26	11 8
2,001--3,000.	10 4	12 34	5 8

TABLE B-4 (CONTINUED--22 OF 28)

15. (Continued)

	Small	Medium	Large
3,001--4,000.	0 0	40 22	5 8
4,001--5,000.	0 0	8 6	11 12
5,001--6,000.	0 0	16 6	26 20
6,001--7,000.	0 0	0 0	11 16
7,001--8,000.	0 0	0 1	5 0
8,001--9,000.	0 0	0 1	5 4
9,001--10,000	0 0	0 0	11 8
10,000+	0 0	0 0	11 72

16. Percentage of gross operating revenue from prepayment:

0	0 100	0 100	0 100
1--10.	43 0	54 0	55 0
11--20.	6 0	8 0	10 0
21--30.	15 0	4 0	0 0
31--40.	4 0	0 0	5 0
41--50.	8 0	0 0	10 0
51--60.	4 0	4 0	5 0
61--70.	4 0	0 0	0 0
71--80.	9 0	8 0	0 0
81--90.	8 0	4 0	0 0
91--100	0 0	19 0	15 0

TABLE B-4 (CONTINUED--23 OF 28)

	Small	Medium	Large
17. Average number of patients seen per day by all physicians in your group:			
0	0 0	0 0	0 0
1--100	38 36	8 8	6 4
101--200	35 41	17 8	6 16
201--300	21 18	13 25	0 4
301--400	4 4	17 32	6 24
401--500	2 1	21 17	12 12
501--600	0 1	13 7	18 16
601--700	0 0	4 2	12 8
701--800	0 0	4 1	12 8
801--900	0 0	4 1	6 4
901--1000	0 0	0 1	12 4
1001+	0 0	0 0	12 0

18. Presence of clinic offices or satellites in other than the main clinic location
 a. Number of clinic satellites:

0	74 77	69 74	37 80
1	19 16	8 18	16 8
2	6 5	8 3	32 8
3	2 1	8 3	16 4
4	0 1	0 2	0 0
5	0 0	8 1	0 0
10	0 0	0 1	0 0

TABLE B-4 (CONTINUED--24 OF 28)

18. (Continued)

b. Average distance of satellites from clinic (miles):

	Small	Medium	Large
1--5.	23 25	25 31	9 0
6--10	8 13	13 28	46 50
11--15	46 35	0 9	18 25
16--20	8 10	25 3	9 0
21--25	0 7	25 6	0 0
26--30	8 3	0 9	0 0
31--35	0 0	0 3	9 0
36--40	0 5	0 3	0 0
41--45	0 2	13 0	0 0
46--50	0 0	0 0	9 0
50+	8 0	0 6	0 25

19. Standing clinical and management committees

a. Standing clinical committees

(1) Clinical Utilization:

No.	100 99	96 97	84 84
Yes	0 1	4 3	16 16

(2) Educational:

No.	93 93	89 85	53 68
Yes	8 7	12 15	47 32

(3) Fee:

No.	98 98	92 97	95 88
Yes	2 2	8 3	5 12

TABLE B-4 (CONTINUED--25 OF 28)

		Small	Medium	Large
19. a. (Continued)				
(4) Medical information:				
No.		94 97	100 93	65 92
Yes		6 3	0 7	35 8

(5) Medical policy:				
No.		96 97	65 91	74 92
Yes		4 3	35 9	26 8

(6) Medical records:				
No.		89 96	81 81	63 56
Yes		11 4	19 19	37 44

(7) Review of professional performance:				
No.		83 93	58 74	25 64
Yes		17 7	42 26	75 36

(8) Review of special performance:				
No.		96 97	77 95	68 84
Yes		4 3	23 5	32 16

(9) Scientific:				
No.		98 99	92 98	79 92
Yes		2 1	8 2	21 8

(10) Specialty:				
No.		98 97	88 95	95 92
Yes		2 3	12 5	5 8

TABLE B-4 (CONTINUED--26 OF 28)

		Small	Medium	Large
19. a. (Continued)				
(11) Supporting services facilities:				
	No.	94 90	73 71	70 76
	Yes	6 10	27 29	30 24

(12) Other:				
	0	85 88	85 86	35 80
	1	9 9	12 12	30 8
	2	4 2	0 2	15 0
	3	2 1	0 0	10 0
	5	0 0	4 0	0 0
	7	0 0	0 0	5 0
	8	0 0	0 0	5 0

b. Standing management committees				
(1) Community relations:				
	No.	98 98	96 99	95 96
	Yes	2 2	4 1	5 4

(2) Compensation, benefits, and insurance:				
	No.	91 88	65 65	55 72
	Yes	9 12	35 35	45 28

(3) Coordination and liaison:				
	No.	96 100	100 98	95 92
	Yes	4 0	0 2	5 8

TABLE B-4 (CONTINUED--27 OF 28)

		Small	Medium	Large
15. b. (Continued)				
(4) Current facilities and maintenance:				
	No.	94	88	89
		94	81	80
	Yes	6	12	11
		6	19	20
(5) Equipment:				
	No.	98	96	100
		98	99	96
	Yes	2	4	0
		2	1	4
(6) Executive/governing:				
	No.	60	42	53
		67	45	60
	Yes	40	58	47
		33	55	40
(7) Fiscal:				
	No.	96	77	60
		91	67	64
	Yes	4	23	40
		9	33	36
(8) Personnel management:				
	No.	87	88	79
		94	81	80
	Yes	13	12	21
		6	19	20
(9) Planning:				
	No.	92	81	63
		95	72	72
	Yes	8	19	37
		5	28	28
(10) Satellite:				
	No.	98	100	84
		99	98	96
	Yes	2	0	16
		1	2	4

TABLE B-4 (CONTINUED--28 OF 28)

19. b. (Continued)

(11) Selection/recruitment:

Small Medium Large

No.	96	81	79
	94	74	80
Yes	4	19	21
	6	26	20

(12) Other:

0	92	81	40
	92	82	50
1	4	15	15
	7	12	25
2	4	4	15
	1	5	21
3	0	0	20
	0	1	4
4	0	0	10
	0	0	0

TABLE B-5

PROFESSIONAL ADMINISTRATORS' RESPONSES BY SIZE AND PAYMENT MECHANISM--
CHIEF RESPONSIBILITY EXPRESSED AS A PERCENTAGE OF SUBSYSTEM TASKS
IN EACH KATZ AND KAHN SUBSYSTEM (COLUMN 2 OF STANDARD LIST)

Subsystem	Chief Responsibility	Fee For Service			Prepayment		
		Small	Medium	Large	Small	Medium	Large
1. Maintenance	No One.....	0	0	0	0	0	0
	Professional Administrator	59	55	52	60	55	53
	Medical Director.....	6	8	7	10	20	17
	Governing Body.....	29	24	20	22	19	16
	Other.....	5	12	21	7	7	14
2. Boundary/Production Supportive-Procurement	No One.....	1	0	0	1	1	0
	Professional Administrator	66	62	54	65	66	56
	Medical Director.....	6	6	9	9	11	15
	Governing Body.....	22	17	13	17	10	7
	Other.....	7	14	24	8	12	22
3. Boundary/Production Supportive-Disposal	No One.....	1	3	2	0	1	0
	Professional Administrator	70	66	60	72	82	53
	Medical Director.....	6	7	9	6	3	14
	Governing Body.....	9	5	5	4	2	4
	Other.....	13	17	24	18	12	29
4. Boundary/Institutional Supportive	No One.....	2	5	4	0	3	2
	Professional Administrator	39	44	39	48	54	31
	Medical Director.....	8	9	9	8	11	27
	Governing Body.....	31	18	17	20	16	18
	Other.....	9	15	22	10	17	16
5. Adaptive	No One.....	1	2	0	3	1	1
	Professional Administrator	64	59	62	62	65	59
	Medical Director.....	6	6	6	11	12	13
	Governing Body.....	24	23	13	15	16	13
	Other.....	5	9	18	7	6	15
6. Managerial	No One.....	0	1	0	0	0	0
	Professional Administrator	44	41	42	48	45	45
	Medical Director.....	5	7	6	13	14	15
	Governing Body.....	46	43	37	34	35	29
	Other.....	4	8	15	3	6	12

TABLE B-6

PERCENTAGE OF PROFESSIONAL ADMINISTRATORS' RESPONSES BY
SIZE AND PAYMENT MECHANISM--CRITICAL TASKS BY FINE'S METHODOLOGY

	Small	Medium	Large
1. First most important task			
a. Data:			
(1) No significant relationship	2 1	0 0	0 0
(2) No significant relationship	0 0	0 0	0 0
(3) Comparing	0 0	0 0	0 0
(4) Copying	0 0	0 0	0 0
(5) Computing	2 3	0 1	5 5
(6) Compiling	29 28	5 19	11 25
(7) Analyzing	31 15	32 25	16 20
(8) Coordinating.	2 9	18 11	21 15
(9) Synthesizing.	0 0	0 0	0 0

b. People:			
(1) No significant relationship	0 0	0 0	0 0
(2) Serving	0 2	5 0	0 0
(3) Speaking--Signaling	0 0	0 2	0 0
(4) Persuading.	2 2	14 5	0 5
(5) Diverting	2 0	0 0	0 0
(6) Supervising	20 26	0 20	21 20
(7) Instructing	0 1	0 1	5 0
(8) Negotiating	8 12	27 17	21 10
(9) Mentoring	2 0	0 0	0 0

TABLE B-6 (CONTINUED--2 OF 5)

	Small	Medium	Large
2. Second most important task			
a. Data:			
(1) No significant relationship	0 0	0 0	0 0
(2) No significant relationship	0 0	0 0	0 0
(3) Comparing	0 0	5 0	0 0
(4) Copying	0 0	0 0	0 0
(5) Computing	6 6	0 3	0 0
(6) Compiling	25 26	9 20	16 20
(7) Analyzing	19 16	18 20	16 20
(8) Coordinating	6 3	9 7	21 5
(9) Synthesizing	0 0	0 0	0 0

b. People:			
(1) No significant relationship	0 0	0 0	0 0
(2) Serving	2 2	0 0	0 5
(3) Speaking--Signaling	0 1	0 2	5 0
(4) Persuading	10 2	18 6	0 10
(5) Diverting	0 1	5 2	0 0
(6) Supervising	31 35	14 32	21 25
(7) Instructing	0 1	0 25	5 5
(8) Negotiating	0 7	0 8	16 10
(9) Mentoring	0 0	0 0	0 0

TABLE B-6 (CONTINUED--3 OF 5)

3. Third most important task

a. Data:

	Small	Medium	Large
(1) No significant relationship	0 0	0 0	0 0
(2) No significant relationship	0 0	0 0	0 0
(3) Comparing	0 2	0 2	0 0
(4) Copying	0 0	0 0	0 0
(5) Computing	4 7	5 0	0 0
(6) Compiling	31 27	27 25	16 21
(7) Analyzing	8 16	18 20	26 32
(8) Coordinating	4 3	14 5	16 0
(9) Synthesizing	0 0	0 0	0 0

b. People

(1) No significant relationship	0 0	0 0	0 0
(2) Serving	2 1	0 0	0 0
(3) Speaking--Signaling	0 2	0 4	5 0
(4) Persuading	8 9	5 12	5 16
(5) Diverting	2 1	5 0	0 0
(6) Supervising	40 27	23 16	21 26
(7) Instructing	0 2	5 4	5 0
(8) Negotiating	0 5	0 13	5 5
(9) Mentoring	0 0	0 0	0 0

TABLE B-6 (CONTINUED--4 OF 5)

	Small	Medium	Large
4. Fourth most important task			
a. Data:			
(1) No significant relationship	0 0	0 0	0 0
(2) No significant relationship	0 0	0 0	0 0
(3) Comparing	6 4	5 3	0 6
(4) Copying	0 0	0 0	0 0
(5) Computing	8 7	35 2	5 0
(6) Compiling	33 35	15 29	21 35
(7) Analyzing	23 14	5 26	11 24
(8) Coordinating.	2 3	5 3	11 6
(9) Synthesizing.	0 0	0 0	0 0

b. People:			
(1) No significant relationship	0 0	0 0	0 0
(2) Serving	0 0	0 0	11 0
(3) Speaking--Signaling	4 4	0 3	5 12
(4) Persuading.	8 11	15 9	16 6
(5) Diverting	4 2	10 0	5 0
(6) Supervising	4 14	5 18	21 6
(7) Instructing	2 1	5 1	5 0
(8) Negotiating	4 5	5 7	0 6
(9) Mentoring	0 0	0 0	0 0

TABLE B-6 (CONTINUED--5 OF 5)

5. Fifth most important task
a. Data:

	Small	Medium	Large
(1) No significant relationship	0 0	0 0	0 0
(2) No significant relationship	0 0	0 0	0 0
(3) Comparing	5 8	0 8	6 7
(4) Copying	0 1	0 0	0 0
(5) Computing	2 5	6 2	0 0
(6) Compiling	29 26	13 21	0 20
(7) Analyzing	17 18	19 19	17 20
(8) Coordinating.	2 1	13 1	6 7
(9) Synthesizing.	0 1	0 0	0 0

b. People:

(1) No significant relationship	0 0	0 0	0 0
(2) Serving	0 4	0 2	6 0
(3) Speaking--Signaling	5 3	0 8	6 7
(4) Persuading.	19 13	31 17	17 0
(5) Diverting	2 1	0 2	0 0
(6) Supervising	7 10	19 9	22 13
(7) Instructing	5 1	0 0	6 0
(8) Negotiating	7 7	0 10	17 13
(9) Mentoring	0 1	0 0	0 13

TABLE B-7

PROFESSIONAL ADMINISTRATORS' RESPONSES BY SIZE AND PAYMENT MECHANISM--
 PROFESSIONAL ADMINISTRATORS' AVERAGE PERSONAL INVOLVEMENT BY WHO IS
 CHIEFLY RESPONSIBLE IN EACH KATZ AND KAHN SUBSYSTEM (COLUMN 2--3 INTERACTION)

Subsystem		Chief Responsibility		Fee For Service			Prepayment		
				Small	Medium	Large	Small	Medium	Large
1. Maintenance									
	No One.....			.09	.10	.08	.02	0	.21
	Professional Administrator			4.39	4.16	4.33	4.13	3.90	4.07
	Medical Director.....			.86	1.16	.98	1.11	2.05	1.41
	Governing Body.....			2.71	2.63	2.47	2.04	2.74	2.67
	Other.....			1.41	1.41	2.06	1.10	1.30	1.78
2. Boundary/Production Supportive-Procurement									
	No One.....			.06	.15	0	.04	.32	.10
	Professional Administrator			4.39	4.26	4.24	4.00	3.95	3.95
	Medical Director.....			.62	.70	.64	1.19	1.55	1.98
	Governing Body.....			2.40	2.43	2.05	2.05	1.89	1.64
	Other.....			1.05	1.68	2.37	.98	1.47	2.09
3. Boundary/Production Supportive-Disposal									
	No One.....			.11	.08	.18	0	.05	0
	Professional Administrator			3.91	3.64	3.95	3.58	4.01	3.29
	Medical Director.....			.40	.54	.54	.29	.32	1.44
	Governing Body.....			.63	.45	.46	.45	.36	.40
	Other.....			.93	1.10	1.21	1.11	1.16	1.44
4. Boundary/Institutional Supportive									
	No One.....			.08	.45	.20	0	.18	.06
	Professional Administrator			2.07	2.38	1.27	2.55	3.45	2.01
	Medical Director.....			.33	.45	.67	.38	.68	1.16
	Governing Body.....			1.31	1.00	1.57	1.01	1.53	1.03
	Other.....			.42	.66	.98	.70	1.06	1.00
5. Adaptive									
	No One.....			.13	.28	0	.29	.10	.05
	Professional Administrator			4.21	4.16	4.29	3.74	4.05	4.11
	Medical Director.....			.59	.83	.90	1.20	1.87	1.68
	Governing Body.....			2.56	2.57	2.00	1.78	2.43	3.04
	Other.....			.66	1.08	1.62	.65	.95	1.69
6. Managerial									
	No One.....			.15	.19	.13	.28	.40	0
	Professional Administrator			4.39	4.28	4.39	4.02	4.04	4.12
	Medical Director.....			1.02	1.38	1.59	1.55	1.97	2.20
	Governing Body.....			3.10	3.18	2.84	2.67	3.29	3.02
	Other.....			1.50	2.02	2.15	1.15	1.60	2.42

APPENDIX C

Appendix C-1	Description of Index Number Used in Future of Health Care Study (To be provided later)
Table C-1	ACCM Nominal Group--Question 1
Table C-2	ACCM Nominal Group--Question 2
Table C-3	California Group Practice Administrators Nominal Group--Question 1
Table C-4	California Group Practice Administrators Nominal Group--Question 2
Table C-5	Physician Nominal Group--Question 1
Table C-6	Physician Nominal Group--Question 2
Table C-7	Comparison of Prescenario With Postscenario Average Personal Involvement for Each of the Three Scenarios By Katz and Kahn Subsystem (Column 3 of Standard List)
Appendix C-2	Summary Scenarios

APPENDIX C-1

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223

Computation of Index Numbers for Future Studies
(Normalized Scores)

Nominal Group #1 -- ACCM

N = 9 Scores Reported as Rating

Rating $\div$ (N x 100) = Normalized Score = Index

Example:

Rating = 865

Index = $\frac{865}{9 \times 100} = \frac{865}{900} = 0.96$

Nominal Group #2 -- California Administrators

N = 10

Example:

Rating = 600

Index = $\frac{600}{10 \times 100} = \frac{600}{1000} = 0.60$

Delphi #1 -- Starkweather

N = 24 Scores as Percentile Ratings

Rating Given As:

Probability of Occurrence (O)	90%	50%	10%
Percentage of Panelists Indicating (P)	.75	.10	.05

Rating = $N [(P_1 \times O_1) + (P_2 \times O_2) + (P_3 \times O_3)]$

Index = $\frac{\text{Rating}}{N \times 90} = \frac{N [(P_1 \times O_1) + (P_2 \times O_2) + (P_3 \times O_3)]}{N \times 90}$

Index = $\frac{(P_1 \times O_1) + (P_2 \times O_2) + (P_3 \times O_3)}{90}$

Example: $I = (.75 \times 90) + (.10 \times 50) + (.05 \times 10) =$

$$\frac{67.50 + 5.00 + .50}{90} = \frac{73}{90} = 0.81$$

Delphi #2 -- Bergwell

N = 15 Scores Reported as "Mean Probabilities"

Mean Probability = Index as Calculated in the Other
100

Example: Mean Probability = 86.5

$$\text{Index} = \frac{86.5}{100} = 0.87$$

TABLE C-1

ACCM NOMINAL GROUP
THE DENVER HILTON
Jan. 31 - Feb. 1, 1975

Question: 1. What do you predict will happen in the health care field that will affect the future role of group practice administration (objective)?

	First Round -Ranking- Total Rank		Second Round -Rating- Total Rank	
1. Government controlled health maintenance for every citizen (Fee-for-service extinct, ~~MHI~~ will be a reality).	24	1	865	1
2. Increased volumes of care for each patient (more use of more procedures by each patient).				
3. In MHI for 22 years, poor medical care, hence return to conventional delivery system.				
4. Emphasis on large health center which will support satellite offices (urban, suburban, rural).	9	4	435	3
5. Expanded use of ancillary, more specialized personnel.	3	8	-	-
6. Large health care centers broken down in the center into: acute, chronic, and preventive care.	5	6	149	6
7. Health care centers will provide a broader spectrum of services.	3	8	-	-
8. Solo practitioner will become extinct, will team up with groups which will enlarge and merge, etc.	8	5	275	5
9. "Doctor" will change with the government paying for their education; hence, many of the lower classes will enter medicine because it's available, resulting in a different set of rules.	2	9	-	-
10. Information exchange will be on more of an international basis because of technological advances.				
11. Centralization of care with networks, efficient (non-overlapping), with outside decisions.				
12. All groups will have to be accredited to participate in MHI, with both physicians and Administrators meeting certain requirements.	5	6	115	7
13. Diminishing fee-for-service, increased prepay/government/insurance health care.	8	5	350	4
14. Delivery of health care will be more specialized, with more physicians/population, less hours/physicians and reduced income.				
15. Centralized data banks will be regionalized with access by Social Security number.	3	8	-	-
16. Employee groups (including physicians) will have a greater influence on the operation of health centers.				
17. Consumers will have an increased role in the decisions.	5	6	110	8
18. Vertical surgery will come into its own.				
19. With advances, physician status will be downgraded, and health care administrators will be responsible to the federally controlled organization of health care.	4	7	-	-
20. Physicians and administrators will be assigned specific areas to work and live in by the federal government.				
21. Return to physicians for primary care with specialists to be located in the health centers.				
22. All employee groups will become unionized.	1	10	-	-

TABLE C-1 (CONTINUED--2 OF 2)

ACCM Nominal Group
The Denver Hilton
Jan. 31 - Feb. 1, 1975
Question 1 Continued

	First Round		Second Round	
	Total	Rank	Total	Rank
23. Equipment used by health care centers will be more complex and expensive.	1	10	-	-
24. Health Care Delivery System will become more complex.	5	6	-	-
25. Medical buildings, as we know them, will become obsolete, buildings will be lighter, more flexible.	18	2	combined with 1	
26. Health care as a right will be mandated (equal health care opportunity).				
27. Strictly controlled malpractice insurance run by federal government, run along lines of no-fault workman's compensation.				
28. Physicians will be less dedicated.				
29. Security will play a prominent role in the construction of buildings.				
30. In large controlled centers, there will be screening with: -Primary Care Physician determine problems -Psychological Social Workers -Surgery on premise with after care on premises -A teaching preventive medical unit.	4	7	-	-
31. A much greater emphasis on ambulatory care (vertical surgery as a part).	13	3	580	2
32. Buildings will be designed by the government with pre-fab, etc.				
33. Hippocratic Oath will be out of vogue.				
34. Change in land usage with fewer autos, more public transportation, hence less parking problems.				
35. Licensing criteria for physicians will change, hence be related to training.				
36. Billing will be changed to an automatic, computerized system.				
37. Increased automation.				
38. Women will play a more prominent role, there will be centralized nurseries.				
39. The South will rise again.				
40. Administrative services for group practice will be handled through a service corporation.	3	8	-	-
41. Doctors choices of medications will be limited (government formulary).	1	10	-	-
42. Elaborate cost accounting will be necessary.	5	6	100	9
43. Time study, motion analyses will become more necessary.				
44. Statistical support will be necessary for all changes, because they will be subject to approval.	3	8	-	-
45. Continuing education will play a greater role for all personnel (physicians, Administrators, RN's, etc.).	2	9	-	-
46. All emergency care will be administered in institutions.				

TABLE C-2
ACCM NOMINAL GROUP
THE DENVER HILTON
Jan. 31 - Feb. 1, 1975

Question: 2. If you were able to control or invent the future of health care delivery, what utopian projections would you make to establish the ideal in group practice administration?

	First Round -Ranking-		Second Round -Rating-	
	Total	Rank	Total	Rank
1. Government should be involved in medical care only by default.	10	4	340	4
2. Better awareness on the part of physicians of patients, their needs, what they are saying and thinking.	11	3	470	3
3. Organizational structure gives the administrator full authority to manage clinic in area of qualifications.	5	7	130	8
4. Quality (not luxury) health care available to all.				
5. Require relicensing or recertification of physicians.				
6. A problem-solving computer for administrators.				
7. Equalization of fees between specialties and proper cost-pricing of all tests.	6	6	225	6
8. Private foundation type funding for clinics, so as to guarantee equal health care for each patient based on need, i.e., removing financial barriers to care).				
9. Get physicians out of the real estate business; get rid of obsolete buildings.				
10. Patients who have means should pay for own care, patients who don't should be helped by the government.	10	4	220	7
11. Complete computerization of medical records, automatic billing procedures.	4	8	-	-
12. Solutions to the many social problems which affect health care (aged, sanitation, etc.).	17	1	600	1
13. Establish accountability for physicians and standards of patient care.	4	8	-	-
14. Public relations rather than economics may be the prime responsibility of the administrator.				
15. Some method of educating physicians, which is not in a completely protected environment, that gives exposure to the rest of the world.	7	5	285	5
16. Mandatory continuing education for all clinic personnel, including support personnel; in-service training (to be included in their salary).	3	9	-	-
17. Every clinic should be an educational center, for employees, patients, and trainees (students), paramedicals, etc.	3	9	-	-
18. The practice of medicine should be allowed to become more competitive (pricing, advertising, etc.).	1	11	-	-
19. Adequate and available supplies of physicians and ancillary personnel.	4	8	-	-
20. A free competitive system well organized, competently staffed health teams enjoying mutual respect, with <u>genuine peer</u> review of physicians, administrators, and fees without substantial government intervention.	14	2	597	2
21. Establish standards of performance to measure effectiveness of administrators.				
22. Recognition by the physician of the profession of administration.	2	10	-	-
23. Adequate policing of quality of physicians by physicians (weed out bad apples).				
24. Preventive medicine should be taught to patients in every clinic.				
25. More trained staff (social workers and paramedicals) in the triage process.				

TABLE C-2 (CONTINUED--2 OF 2)

ACCM Nominal Group
The Denver Hilton
Jan. 31 - Feb. 1, 1975
Question 2 Continued

Jan. 31 - Feb. 1, 1975
Question 2 Continued

	First Round -Ranking-		Second Round -Rating-		
	Total	Rank	Total	Rank	
26. Remove preoccupation with malpractice.	4	8	-	-	
27. Good relations with other organizations in the health care delivery system (hospitals, nursing homes, etc.).	5	7	-	-	
28. Availability of full technological and professional information through visual media equipment placed in every office.	2	10	-	-	
29. Eliminate duplication of expensive equipment and facilities.	1	11	-	-	
30. Establishment of medical services corporations for the purpose of: -purchasing -maintenance -personnel -billing and collections	3	9	-	-	
} leased to physicians.					
31. Legal controls on malpractice plus some realistic method of censuring attorneys who act without proper cause.	1	11	-	-	
32. Screening of new patients by psychiatric social workers to determine whether problem is physical or emotional.					
33. Retain the incentives to physicians to continue practicing.					
34. Provide motivation for tax support of hospitals to cut costs and improve efficiency.					
35. More health educators and better education of patients as to functions and realistic expectation of physician and the HCD system.					
36. Some method of handling indigents without taking a financial beating.					
37. Greater recognition by physicians of psychosomatic diseases, taught in medical school and/or continuing education.					
38. Maintain fee for service medical care system.	2	10	-	-	
39. Establishment of free clinics for indigents.					
40. Changing labor laws to give the employer an even break.					
41. Physicians should be salaried so there would be a realistic base of worth.	1	11	-	-	
42. Control and restriction of physician performance to areas of qualification.					
43. Catastrophic coverage over some percent of annual salary.					
44. No matter what the future, keep all clinic personnel out of the bureaucracy of the civil service system.					

TABLE C-3

CALIFORNIA GROUP PRACTICE ADMINISTRATORS
 NOMINAL GROUP PROCESS MEETING
 SAN FRANCISCO HILTON INN
 August 8, 1975

Question: 1. What do you predict will happen in the health care field that will affect the future role of group practice administration (objective)?

	First Round -Ranking-		Second Round -Rating-	
	Total	Rank	Total	Rank
1. Formalized planning processes.				
2. Price competition.	10			
3. Groups will contract with employers to provide total care to include industrial as well as group (employees and families).	2			
4. Structured fees-for-services will force changes in methods of income distribution, fringe benefits, and mobility.	9			
5. Mandatory multi-phasic clinics in every community with a population of 100,000 and citizens shall be required to take exam every other year.				
6. All clinics will be government owned, operated, or controlled.	39	1	386	10
7. Make greater use of physicians' assistants and/or reduced training for physicians who would play role of triage doctors (primary care).	6			
8. Organization will change to have consumer participation in clinic policy.	21	6	526	5
9. Health care will be provided for the jobless.	10			
10. Government accountability with standard chart of accounting and reporting.	25	3	490	6
11. Closer alignment of groups with hospital - hospital based or shared services.	12			
12. Better informed patient population.				
13. Schools to be used for all well-baby care and immunizations.	7			
14. Future legislation will place tight controls over costs allowable.	22	5	-	-
15. Women shall outnumber men in MGMA by 8% in the year 2000.				
16. Half the physicians will be women.				
17. Greater use of computer storage of health information, probably centrally controlled.	16	8	399	9
18. Clinic patients will have some kind of membership to be seen.	1			
19. All payment for medical services will be by third party.	7			
20. Group practice quality standards review and accreditation.	15	9	480	7
21. Increased use of management engineering techniques in the clinic environment.	20	7	410	8
22. Erosion of the old medical school tie.	4			
23. Doctor groups to be used for sick care only.	8			
24. Constraints will be placed on the freedom to expand, add new specialties, add new equipment.	10			
25. Advertising restrictions will be removed from most medical enterprises.				
26. More sub-specialties in clinic administration.	5			
27. Much, much, much greater involvement (control) of unions with physicians and employees.	21	6	576	2
28. Most large clinics will have a teaching program for employees and professionals.	6			
29. Increased utilization of medical care will cause deterioration of quality.	6			
30. Administrators will be licensed.	6			
31. Mandatory patient education programs.	7			

TABLE C-3 (CONTINUED--2 OF 3)

	First Round		Second Round	
	-Ranking- Total	Rank	-Rating- Total	Rank
32. Decreasing physician income.	13			
33. Employers to contract with hospitals for care on a per diem basis for employees and their families, whether industrial or group.	1			
34. Tremendous growth in numbers of groups and numbers of doctors in the group (i.e., average size of group larger).	23	4	544	3
35. Six semester units of medical patient education will be required of every high school graduate.				
36. Chain, pyramid, or concentric circles clinics system.	8			
37. Ancillary services (optical, pharmaceutical, PT, midwifery) to be provided by non/M.D.'s or at no profit to the M.D. (out of clinic and control financially of doctors)	7			
38. Financial data will be disclosed for public scrutiny.	2			
39. Tremendous increase in numbers of administrative personnel to handle increased load of paper work.	10			
40. Increased out-patient care, e.g., surgical care, etc.	6			
41. Development of clinic associations (cooperative) to share in services and to reduce costs.	9			
42. Educational requirements for clinic administrators will be on a par with hospital administrators.				
43. Easier access to medical care by setting up adolescent clinics and geratology clinics in high schools.	6			
44. Most administrator's and physician income levels to be guaranteed on a scale related to civil service levels.				
45. Government trained paramedics with indentured servitude for training.				
46. Hospitals will lose the battle to become the total providers of health care (clinics will survive!)	1			
47. Ideal clinic will be master clinic with as many satellite clinics as community can justify.	6			
48. Present regulations will bankrupt the provision of health care and we will have a totally new system in 15 years.				
49. Universal health insurance.	21	6	600	1
50. New scientific instrumentation, use of computers and television in the treatment of patients.	3			
51. Diversification of interests by administrators and physicians of companies within and without the health industry.	5			
52. Government administered mal-practice insurance.	26	2	-	-
53. Use of mobile vans for multi-phasic screening to be used by employees in lieu of physicals in the office.	4			
54. With the advent of national health care insurance, a 70% increase in demand for services will destroy the present health care system.	26	2		
55. All administrators will be required to have a data processing degree.				
56. Large chief clinic administrators will be political appointees.				
57. Duties, responsibilities, etc., of clinic administrators to be standardized (less M.D. interference).				
58. Rights of patients will exist to refuse care.				
59. M.D.s will work in shifts around the clock and to use space and facilities more efficiently.	6			
60. Hospitals and medical groups will become public utilities or "The decline and fall of the medical diety."	20	7	-	-
61. Increased technical and educational skills required of administrators to cope with the above.	14	10	530	4
62. Hospital emergency rooms to assume role of doctors office for all after-hours care.	10			
63. Administrators will be the chief decision makers.	10			

TABLE C-3 (CONTINUED--3 OF 3)

	First Round		Second Round	
	Total	Rank	Total	Rank
64. There will be increased use of prepayment and capitation to anticipate medical costs, i.e. to budget effectively.	16	8	-	-
65. Overnight facilities for relatives will become part of larger clinic facilities.				
66. A lower proportion of R.N.s in the clinic.				
67. Elimination of the doctor's mystique with newly graduated doctors being considered as other employees.				
68. More M.D. administrators.	13			

TABLE C-4

CALIFORNIA GROUP PRACTICE ADMINISTRATORS
 NOMINAL GROUP PROCESS MEETING
 SAN FRANCISCO HILTON INN
 August 8, 1975

Question : 2. If you were able to control or invent the future of health care delivery, what utopian projections would you make to establish the ideal in group practice administration?

	First Round		Second Round	
	Total	Rank	Total	Rank
1. Maintained freedom of choice. - doctors and patients - prepaid and fee-for-service	40	1	629	1
2. Less government regulation of private health care.	27	9	575	3
3. Capitation and/or prepayment eliminating billings.	19	8	-	-
4. Eliminate all bureaucratic required reporting that cannot be cost justified, and does not provide useful data not produced by other reports.	11			
5. Employ a method of payment to M.D.s oriented to actual production, and weighted by specialty.	14			
6. Federal-state funded, county-operated, group practice buildings for all medicaid eligible patients, (equipment and service provided by county).	12			
7. Total health care center as the core for all acute illness and accidents, staffed by specialties required, and supported by strategic satellites, all under one administration.	31	3	554	4
8. Schedule work time for physicians.	8			
9. Restrict M.D.s to practice of medicine.	2			
10. Increase supply of well trained M.D.s - decrease supply of lawyers.				
11. Revised mal-practice system. - less costly - justified awards.	36	2	469	6
12. Higher compensation for administrators.	3			
13. Public health facilities for immunizations, well-baby care, patient education, family planning, adolescent counseling, nutrition, and preventive health maintenance.	12			
14. Eliminate government's involvement in all elements in health care delivery.	30	4	603	2
15. Basic economic and personnel subjects required in pre-med.				
16. All medical care should be funded by pre-pay, provided by employers or government.	9			
17. Adopt separation between acute and nonacute care.				
18. Larger and better staffed and equipped multi-specialty clinics operating in voluntary cooperation with other health providers.	13			
19. No unions.	18	9	381	9
20. M.D.s paid in correlation with quantity and quality of work provided.				
21. M.D.s not suitable to groups or with personality problems, be assigned to projects not requiring a group adjustment.				
22. Administrators authorized to eliminate waste where quality of care not effected.	15	10	395	8
23. Prohibit M.D.s from becoming their own landlords.				
24. Low interest, long-term loans for buildings and equipment.	14			
25. Exotic procedures requiring special equipment and staff, be strategically located to avoid duplication.	15	10	460	7
26. Pre-select patients.	11			
27. Require regular peer-review of patient care.	11			

TABLE C-4 (CONTINUED--2 OF 2)

	First Round		Second Round	
	-Ranking- Total	Rank	-Rating- Total	Rank
28. Develop a patient education process to cope with the "worried-well" and "worried-sick".	21	7	355	10
29. Peer-review committees should have power to discipline poor medical practice.	17			
30. VNA for control of chronic illnesses in the home to avoid unnecessary clinic visits.	5			
31. Legal restrictions on mal-practice: - awards - M.D. liability - statute of limitations - attorney contingency fees	25	6	548	5
32. Reasonable transportation system.				
33. Put more money into research to improve health care delivery.	1			
34. Better education for administrative assistants, e.g., insurance clerks, receptionists, etc.	4			
35. Adequate, but reasonable salaries for M.D.s.	8			
36. Shortening of over-populated specialties and requiring those specialists to work in medically under-served areas for two years.				
37. 50% reduction in income taxes.	4			
38. Computerize the medical record and appointments.	4			
39. Increased availability of paramedical personnel.				
40. Compulsory, problem-oriented medical records.	14			
41. M.D.s that are content to practice medicine only, and are content with their salaries.	11			
42. Sufficient M.D.s to care for sick persons unless result of distribution problem.				
43. All graduate medical students and administrators must pass handwriting legibility tests.				
44. Develop a system to adequately monitor quality of care.	4			
45. Assignment of M.D.s in the hospital for hospital practice, and allowing sufficient coverage in the office for appointments and walk-ins.	4			
46. Never having to explain what "overhead" is.	3			
47. Minimal 3-day notice for M.D. time-off.				
48. M.D.s would never exaggerate or lie.				
49. 100% government control and ownership of all health care.				
50. The South won't rise again.				
51. Allow lay ownership of medical practices.				

TABLE C-5

PHYSICIAN NOMINAL GROUP PROCESS
DENVER HILTON HOTEL
December 6, 1975

QUESTION #1: What do you predict will happen in the health care field that will effect the future role of group practice administration?

	First Round -Ranking- Total Rank		Second Round -Rating- Total Rank	
1. Increase in group practice in large urban areas, professional resistance in suburban and rural areas.				
2. Fragmentation will occur in management as it has in medicine (specialization in administration will produce fragmentation) good and bad.	9			
3. Most practitioners will attempt to join groups already established, primarily for economic rather than philosophic reasons.	18	7	495	3
4. Increased government intervention with ultimate public utility approach to health.	23	4	370	10
5. Planning and financing of health care facilities will become major problems with obligatory cost accounting and consumer involvement.	9			
6. Increase in prepayment over fee-for-service type of remuneration.	18	7	392	7
7. Development of more complete systems for ambulatory medical care services, including that for first, second, and third echelons.	6			
8. Unionization of ambulatory personnel with the clinic or group.	16	8	252	
9. Increasing pressures to provide first dollar comprehensive prepaid health care.	9			
10. Groups will assume greater educational functions at all levels with academic accreditation.	4			
11. Hospitals will influence and form the hiatus of medical care.	9			
12. New groups of physicians will form, hospital based, or otherwise--for help in operating, they will turn to AMA, AHA--form service bureaus which will fail:				
13. Groups will be forced to make major decisions regarding regionalization.	16	8	380	8
14. Net take home pay for administrators and MDs will decrease in proportion to the inflationary spiral.	2			
15. Less money for the acquisition of facilities and equipment.	2			
16. Regionalization of health care delivery systems, in part in some areas, total in other areas.	9			
17. Increasing number of consumer boards (balance, lay professionals) with input to administration to influence quality vs. cost.	21	5	418	5
18. Increasing third-party pressure for monitoring quality and cost.	10			

TABLE C-5 (CONTINUED--2 OF 4)

QUESTION #1 (Continued)

	First Round --Ranking--		Second Round --Rating--	
	Total	Rank	Total	Rank
19. Development of rotational personnel programs and regionalized services (e.g., "branch banking").	6			
20. Increased competition (patients, equipment, MDs, all) from medical schools caused primarily by government (every level) intervention.	6			
21. MGMA and AGPA will be involved late (by default) in educating newcomers to group practice	6			
22. Major changes in the image of physicians; will influence the kind of people entering the profession.	7			
23. Administration will be required to take a more active political role in their communities.	23	4	424	4
24. Increased involvement of government in licensing and accrediting of MDs and non-MD professionals.				
25. Federally supervised evaluation of medical care as to: quality, cost effectiveness, efficiency, availability.	30	2	815	1
26. Continued government encouragement of group practice through financial incentives, tax breaks, etc.				
27. Increasing demands for preventive medicine and education--departments of education manned by health education specialists.	5			
28. Groups will use physician managers specifically trained in clinical and managerial skills.	12	10	259	10
29. Continue to put medical schools first and at center of all medical care.	6			
30. Pressure from public and union/management coalition will force the establishment to allow favorable economic treatment for groups.	4			
31. Society will turn their attentions more to accessibility and quantity and away from quality of care; hence, the tension will shift to smaller groups away from highly technical (quantity instead of quality).	11			
32. Patients will receive less personalized care--hence, more complaints at the front office.				
33. Increased teaching and educational roles for MDs in group practice.	8			
34. Major consumer involvement to influence numbers and types of MDs and other types of health care professionals; thus, medical health care delivery.	7			
35. Increased pressure and acceptance for regionalized group practice particularly in rural areas.	5			
36. Unions and others will push hard for capitation prepayment, preferably by agreement with existing groups, if need be by forming their own.				
37. Increased use of para-professionals will create status problem and medical staff organization, compensation.	12	10	196	

TABLE C-5 (CONTINUED--3 OF 4)

QUESTION #1 (Continued)

	First Round		Second Round	
	Total	Rank	Total	Rank
38. Increased decremental quality of medical care, caused by intervention of unions, consumers, government, will make entire field less attractive to bright minds.	8			
39. An out-patient oriented allied health culture will develop its own training programs and will seek their own recognition.	9			
40. Consumerism within ten years will fade away.	1			
41. Computers will have an increased role in: 1) appointments 2) billing 3) reporting 4) record keeping 5) statistical analysis 6) clinical care.	20	6	378	9
42. Economics as part of the behavioral science curriculum will be introduced into all undergraduate and graduate training programs.				
43. Mass screening will move out of clinic and emerge as an entirely new discipline with its own personnel and its own plant.	7			
44. Recognition of the difference between health and medical care with clinics medical care co-functioning with social and health agencies.				
45. Federal government will finally be forced to recognize, certify, and license four or five levels of medical care.	4			
46. Formation of a federation of group practice providers (including MGMA, AGPA, group practice, hospitals, etc.)				
47. Increase in doctor's unions.				
48. Development of comprehensive patient education systems for all health care matters.	1			
49. Many bright minds enter health care field, but they will look at it differently.	4			
50. Terrible difficulties planning because of government inconsistencies.	4			
51. Required continuing education and reevaluation of physicians for relicensing.	8			
52. Rapid growth of clinics (increased number of MDs) is going to set up great internal pressures; hence, great difficulty in managing.	26	3	417	6
53. Formal forms of MHI which will require accommodation by clinics.				
54. In three to five years, malpractice will not be a problem.				
55. Physician's workweek will decrease in the number of hours.				
56. Pressures and incentives to put MDs in rural and ghetto areas.	1			
57. Federal research monies will be carefully allocated, rigidly controlled, and monitored for cost effectiveness.				
58. Development of almost totally prepaid health care systems.	9			

TABLE C-5 (CONTINUED--4 OF 4)

QUESTION #1 (Continued)

	First Round		Second Round	
	Total	Rank	Total	Rank
59. National Health Insurance will become a reality in five years, probably through the insurance industry, subsidized where necessary by feds, prepayment, and HMOs will disappear.	35	1	661	2
60. Within ten years, health care will no longer occupy as great a public interest.	3			
61. Loan repayment schemes will fail in rural and inner city areas.				
62. Fee-for-service will always be a part of the medical scene.	1			
63. More women will be involved in medical care.				
64. By the year 2,000 a better (not utopian) process of medical care will evolve.				
65. Universal data bank via social security number will be available on all patients.	13	9	75	
66. Medical education will be rigidly controlled at both undergraduate and graduate levels.	7			

TABLE C-6

PHYSICIAN NOMINAL GROUP PROCESS
DENVER HILTON HOTEL
December 6, 1975

QUESTION #2: If you were able to control or invent the future of health care delivery, what utopian projections would you make to establish the ideal in group practice administration?

	First Round		Second Round	
	Total	Rank	Total	Rank
1. All medical care will be delivered by multi-specialty groups, with or without satellites (composed either of MDs or paramedics).	45	1	613	1
2. Maintain fee-for-service system; okay to balance with prepaid.	14	8	297	10
3. Multi-specialty health centers located regionally according to population needs.	2			
4. Health planning bodies staffed mainly by providers, with informed laymen consumers in an advisory capacity only.			79	
5. Total availability to the total population.	37	2	490	5
6. Establish regional health care systems with appropriate personnel distribution.	30	3	535	3
7. Delivery of health care should integrate in and out-patients; in-patient facilities should be controlled by the out-patient groups.	9			
8. Encourage a balanced team (i.e., MD, nurse, consumer, dentist, etc.) approach to the development of a health care system that the U.S. can afford and live with.	17	6	560	2
9. Eliminate solo practice.				
10. Health care monitoring (cost and quality) standards should be set by groups such as: MGMA, AGPA with input by third-parties (government, insurance, etc.) federal input limited to this only.	29	4	343	9
11. Development of harmonious balance between acute and preventive ambulatory care.				
12. Malpractice costs be shared community and professional responsibility with use of appropriate peer review and ethics committees.	6		20	
13. Greater use of and subsidization for group practice facilities and personnel in the education of MDs, non-MD professionals, and paramedical personnel.	8			
14. High capability to triage the sick, the well, and the worried-well	4			
15. Top administrator of regional health center should be an MD with specialty training in administration.	14	8	300	7
16. Mandatory, binding arbitration for all liability, professional and otherwise.	18	7	344	8
17. Set up more post-graduate schools and encourage use of same to train MD administrators.				
18. Develop a flexible capitation system capable of full prepayment but adaptable to divergent cost coverages.	9			

TABLE C-6 (CONTINUED--2 OF 3)

QUESTION #2 (Continued)

	First Round --Ranking--		Second Round --Rating--	
	Total	Rank	Total	Rank
19. Pluralistic methods of prepayment be allowed to continue (capitation based on quasi-fee-for-service or fee-for-service).	6			
20. Continuance of development of third-party payment for appropriate out-patient procedures.	1			
21. Develop national mandatory National Health Insurance, premiums to be funded by private, industrial fringe benefits, and federal funds for aged and indigent.	23	5	405	6
22. Minimum of government intervention at all levels (federal, state, local).	13	9	45	
23. Comfortable MD income and retirement benefits, based on periodic group peer review.	9			
24. Medical education and training organized so that generalists are "captains" of care and specialists are consultants.	10			
25. Guaranteed reimbursement for all legitimate services regardless of where or by whom rendered.	4			
26. Greater effort in education of lay public in the preservation of their health and the cost of medical care, with its limitations.	4			
27. Create independent government agency with all executive staffing by personnel with identified clinical, planning, and administrative capabilities.	3			
28. Hospital based group practice where feasible. (MDs not hospital employees)	5			
29. All clinics should provide on an extensive scale, patient education, provided by health education specialists funded by all third party carriers.	7			
30. Continued development of paramedical system, acceptable to the provider and the consumer, and <u>controlled</u> .	6			
31. Develop an independent, non-federal organization, consisting of research, academic, and practicing health professionals, to establish the proper balance in energy expenditure in research and clinical medical education.				
32. Preservation of traditional lines of referral, without interference by arbitrary or geographic boundaries.	9			
33. Primary role of medical schools is basic science education, with all clinical training in regional health systems.	4			
34. Clinical education provided by groups should be adequately reimbursed.				
35. Institute into the medical school curriculum instruction and experience in health care administration, so that all MDs have some knowledge and interest in this area.	8			
36. Develop a rural health strategy based on groups integrated from primary through tertiary care levels.	5			
37. Adequate education and training of both MDs and laymen in group practice administration.	2			

TABLE C-6 (CONTINUED--3 OF 3)

QUESTION #2 (Continued)

	First Round -Ranking-		Second Round -Rating-	
	Total	Rank	Total	Rank
38. Much more attention will be paid to transportation of patients to regional health facilities, rather than establishing numerous small clinics.	7			
39. Return to a system that accepts the most qualified individuals rather than "filling" medical schools.	3			
40. Developing a comprehensive, viable medical communications system, providing the modalities of literature review and continuing education for the practicing health professional.	13	9	524	4
41. Physical facilities planning to be strongly influenced by knowledgeable experienced MDs.				
42. Consolidate quality assurance along due care lines, cutting down on fragmented surveys.	6			
43. Encourage (mandate) greater (majority) MD participation of development of a practical health delivery system.	7			
44. Eliminate medical school tuition and base admissions only on capabilities for excellence.				
45. Sophistication in data processing in the business office and in appropriate clinic activities.	3			
46. MDs in top management will have 40 hour weeks, and at least six weeks of annual time off, with a minimum of two of these weeks spent on education.				
47. Self-care facilities established at all hospital based group practices, for continuing patient care, rehabilitation, and education.	3			
48. Create periodic sabbaticals without financial penalties, to prevent medical professional stagnation.				
49. Group managers will have nationally standardized prerequisite college training programs, degrees, and internship requirements and will be compensated on level with MDs.	10			
50. Greater integration and cooperation between MDs and lay administrators, both of whom are well-trained.	12	10	279	
51. National licensure of all MDs.	4			

TABLE C-7

COMPARISON OF PRESCENARIO WITH POSTSCENARIO AVERAGE PERSONAL
INVOLVEMENT FOR EACH OF THE THREE SCENARIOS BY
KATZ AND KAHN SUBSYSTEM (COLUMN 3 OF STANDARD LIST)

Subsystem	Prescenario			Postscenario			Difference		
	1	2	3	1	2	3	1	2	3
1. Maintenance	3.74	3.79	3.40	3.63	3.63	3.56	-.11	-.16	.16
2. Boundary/Production Supportive--Procurement	4.15	4.00	4.28	3.86	4.15	3.92	-.29	.15	-.36
3. Boundary/Production Supportive--Disposal	3.49	3.53	3.47	3.53	3.57	3.38	.04	.04	-.09
4. Boundary/Institutional Supportive	3.73	3.90	2.83	3.50	3.87	3.67	-.23	-.03	.84
5. Adaptive	3.86	4.23	3.74	4.15	3.90	3.63	.29	-.33	-.11
6. Managerial	3.70	3.83	3.53	3.61	3.72	3.61	-.11	-.11	.08
Total	3.75	3.84	3.56	3.68	3.75	3.62	-.07	-.09	.06

APPENDIX C-2

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SCENARIO A

SCENARIO OF THE FUTURE OF HEALTH CARE

By 1985, the United States will have a federally sponsored national health insurance program. It will not be patterned after the British model; rather it will be solely a health insurance system, totally controlled and administered by the federal government. It will have evolved through two different stages, having begun with a catastrophic insurance program, but ultimately having reached the point of including comprehensive health insurance coverage for all Americans.

While the government will not control health care, as it might under a national health service, its control will be extensive. Instead of a totally controlled system, the approach taken in the U.S. will consist in centralization through planning boards. These planning boards/health service agencies will be responsible within each region for approving not only health care facility expansion and equipment addition, but also the specialty and geographic distribution of physicians. Quality of care will also be supervised through extensions of the Professional Standards Review Organizations. In other words, government intervention in terms of costs, quality, and services will be substantial but it will continue to be of the current multi-focal type. No single office or agency will be solely responsible for regulating health care delivery in the U.S.

The advent of this comprehensive national health insurance program will not, however, radically alter the predominant payment modes. A significant portion of the health care sector will continue to be reimbursed on a fee-for-service basis, even though the extent of prepayment will increase.

Along with the movement toward a national health insurance program, collective action by consumers will be increasing. This participation will initially take the form of political action, but by 1985 consumers will compose the majority of the regional planning boards/health service agencies. Their decisions will significantly influence not only facilities and services, but also physician distribution.

As part of this same movement toward collective action on the part of those feeling overwhelmed by the health care delivery system, unions of physicians and non-physicians employees, respectively, will form and become influential forces. While the unions in the health field will be few, large and powerful, physicians and non-physicians will be separate.

For economic reasons and through regulatory incentives, more physicians will become associated with medical group practices. These groups will increase both in numbers and in size with ultimately more than 50% of practicing physicians in groups. These groups will not only be hospital based but also affiliated, i.e., under the same management as the hospital. The rapid increase in size and numbers of groups, as well as the different organization bases, will contribute to great internal pressures and demands for highly skilled administrators. One unfortunate consequence of this rapid expansion will be the accompanying failure of overstressed or underexperienced groups.

SCENARIO B

SCENARIO OF THE FUTURE OF HEALTH CARE

By 1985, the United States will have a federally sponsored national health insurance program. It will not be patterned after the British model; rather it will be solely a health insurance system. This insurance program will be jointly administered through the federal government and private insurers as is currently the case with Medicare. This national health insurance program will evolve in two stages, beginning with catastrophic insurance, but culminating in comprehensive health insurance coverage for all Americans.

It is important to emphasize that this insurance program will not be accompanied by increases in control over the distribution of physician manpower, services and facilities in health care. The only significant intervention will be federal supervision of the evaluation of the quality of care.

Health planning boards will exist, but their control will be accomplished through cost and quality monitoring. The end result of this two-pronged federal supervision will be to establish health care as a public utility with the appropriate regulatory mechanisms.

The advent of a comprehensive national health insurance program and public utility approach to regulation will not, however, radically alter the predominant payment modes. A significant portion of the health care sector will continue to be financed through fee-for-service, even though the extent of prepayment will increase.

Along with the movement toward national health insurance, collective action by health consumers will increase. Their participation in clinic medicine will however, be limited to occupying positions on voluntary advisory boards to group practices.

As part of this same movement toward collective action, unions of non-physician employees in group practice settings will become viable and influential. With physicians able to maintain a sense of autonomy through group practice, there will be no great increase in the unionization of physicians.

Predominantly for economic reasons, more physicians will become associated with medical groups. Group practices will increase both in numbers and size, but they will not include all or even a significant majority of physicians. These groups may be located at or near hospitals but they will not be affiliated with or controlled by hospitals. This orderly growth in group practice will lead to more successful groups and stability in the clinic field with modestly increased demands on the skills of administrators.

SCENARIO C

SCENARIO OF THE FUTURE OF HEALTH CARE

By 1985, the United States will have a federally sponsored national health insurance program. It will be patterned after the British system, that is it will be a total system, a national health service, not just an insurance program. This system will evolve in stages beginning with a catastrophic national health insurance program, but ultimately embracing comprehensive health care under one system and for all Americans.

The advent of this comprehensive national health service will not, however, radically alter the predominant payment modes. A significant portion of the health care sector will continue to be reimbursed on a fee-for-service basis, even though the extent of prepayment will increase.

Along with the movement toward a national health service, collective action by consumers will be increasing. Their participation will initially take the form of political action, but by 1985 consumers will compose the majority of the local community health decision making boards mandated under the legislation establishing this country's national health service.

As part of this same movement toward increased collective action, there will be attempts to unionize both physicians and non-physician employees in group practices. However, these unionization attempts will be running counter to the federal thrust of essentially nationalizing health services. The struggle will be exceedingly intense, but unresolved by 1985.

Physicians, by federal mandate, will become associated with medical groups. Group practices, as part of the federally established national health service, will include all practicing physicians. These group practices will, in turn, be part of regionally organized health care delivery systems under federal control. This rapid and involuntary increase in size and numbers of groups will result in great internal pressures and demands for highly skilled administrators.

APPENDIX D

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Annotated Data Tables

The annotated data tables consist of all the data compiled for this final report. These data are organized in a supplementary document, and the supplement's contents are presented in this appendix.

These tables of annotated data may be ordered from the Center for Research in Ambulatory Health Care Administration, 4101 East Louisiana Avenue, Denver, Colorado, 80222. With your order, please specify the table number of the table which you desire. There will be a slight charge for reproduction and handling costs.

Annotated Data Tables

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